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## **AMA submission**

# **Pharmacy Remuneration and Regulation Review**

### **- interim report**

The AMA welcomes the opportunity to respond to the interim report developed by an independent panel and released for public comment in June 2017.

Overall we consider the recommendations, if implemented, will benefit consumers by improving access to affordable medicines and enhancing the quality of medicines related care provided by pharmacists.

The AMA's submission focuses on the recommendations and options described in the interim report which impact patient care. We have not reiterated comments and views made in our previous submission of 2016 unless relevant to this report.

#### **Consumer support (Chapter 2)**

The recommendations and options relating to patient access to medicines and their experiences within pharmacies appear sensible and well considered.

In particular, the AMA supports:

- improvements to the PBS Safety Net which would enhance patient's understanding and access, for example, the introduction of a central electronic system that automatically tracks individual patient PBS expenditure;
- audits of pharmacy compliance with medicines dispensing requirements, such as correct medicines labelling and the provision of Consumer Medicines Information leaflets, in line with State/Territory legislation and Pharmacy Board of Australia and Pharmaceutical Society of Australia guidelines; and
- improvements to electronic prescription systems and medication records to enhance continuity of care and reduce medication errors. However the AMA notes that prescribing software would require updating to enable full electronic prescribing and that a small, but still significant, proportion of medical practitioners do not use these systems, especially in rural/remote locations with poor internet connections.

### **Complementary medicines (Chapter 3)**

The AMA supports the Review recommendation that homeopathic products should not be sold in PBS-approved pharmacies. Selling these products in pharmacies encourages consumers to believe they are efficacious when they are not.

The AMA also supports the recommendations relating to other complementary medicines which would: better help consumers understand that these medicines have not been assessed for effectiveness in the same way as S2, S3 and prescription medicines; and facilitate opportunities for pharmacists to discuss medicine choices with consumers before they purchase these products, for example, whether there are risks of adverse interactions with other medicines.

### **Funding for primary health care services (Chapter 4)**

The AMA notes the interim report proposal that if pharmacists provide a service that is also offered by alternative primary health care professionals, the same government payment should be applied that service.

While a service may superficially appear the same, it is important to recognise that the delivery, quality and comprehensiveness of that service may differ between health professionals and the context within which it is provided.

For example, a patient administered a flu vaccine in a pharmacy just receives a flu vaccine.

A patient receiving a flu vaccine administered by a general practitioner also receives a preceding consultation which includes a health assessment specific to that patient, based on a sound understanding of the patient's past history and health needs. This might include a check whether the patient's other recommended vaccinations are up-to-date, whether a cervical screening test is due, a blood pressure check if appropriate, a check of the patient's adherence and tolerance of any prescription medicines, and any other appropriate and (evidence-based) opportunistic preventative health care.

Even if the general practice employs nurse practitioners to deliver the vaccine itself, a patient has first been assessed by a general practitioner who continues to be close at hand if needed.

If the Commonwealth Government were to consider paying pharmacists to administer flu vaccines to high risk populations, the services provided by a pharmacist and a medical practitioner in this context would not be equivalent. Clearly there would also need to be research on whether flu vaccinations in pharmacies are cost-effective in comparison to a flu vaccination in a general practice clinic given the value-add provided in the latter service.

Any cost-benefit analysis would also need to take into account the indirect costs of delayed or missed diagnoses leading to higher cost care, that are more likely when care is fragmented by patients relying on health care provided by a pharmacist.

The AMA agrees with the recommendations in the interim report that government-funded services should be evidence-based and cost-effective. Pharmacy-based services that do not meet

these criteria, such as the Amcal's *Pathology Health Screening Service* targeting "relatively young and fit customers ... for general health purposes ... as opposed to risk assessment or diagnosis" should not be eligible for government funding (source: Amcal senior pharmacist James Neville quote at <https://ajp.com.au/news/pharmacy-screening-opportunistic-wasteful/>).

The AMA's earlier submission to this review expanded in some detail regarding the push by the Pharmacy Guild, motivated by revenue generation, to expand the scope of practice of pharmacists into the provision of medical services. We reiterate our deep concerns about the potential for duplication of services and increased fragmentation of care when this occurs.

We commend the independent panel for stressing the importance of health care services only being funded by government when there is evidence they are effective and cost effective.

### **Pharmacy location rules (Chapter 5)**

The AMA has already stated its views on the barriers imposed by current pharmacy location rules in its previous submission to the Review, and in numerous earlier submissions to Government.

The AMA supports changes to pharmacy regulation which would allow more pharmacies and medical practices to be co-located. The current restrictions are inflexible and are difficult to justify in terms of public benefit.

AMA understands that the Australian Government has entered into an agreement with the Pharmacy Guild of Australia to continue indefinitely the current protections the rules provide to Guild members.

However, the AMA is disappointed that the Government has made this decision despite the obvious benefits that would accrue by allowing access to high quality primary health care services in a way that is convenient to patients, enhances patient access and improves collaboration between health care professionals.

Facilitating collaboration between medical practitioners and pharmacists will only improve patient outcomes through less medication mismanagement and better medication compliance.

### **Scope of future community pharmacy agreements (Chapter 7)**

The AMA agrees there are benefits in future community pharmacy agreements being limited to remuneration for the dispensing of PBS medicines and associated regulation.

This would allow pharmacy programs, such as medication adherence and management services currently funded under the Agreement, to be funded in ways that are more consistent with how other primary care health services are funded.

Given these programs are about providing health services, rather than medicines dispensing per se, it makes sense for them to be assessed, monitored, evaluated and audited in a similar way to medical services under the MBS. Approximately \$1.2 billion has been provided to pharmacies

under the current community pharmacy agreement without this level of transparency and accountability. No evaluations of pharmacy programs under the Sixth Community Pharmacy Agreement have been made public.

Moving pharmacist health services outside of the Agreement would also open the way for more flexible models of funding, for example, support for pharmacists working within a general practice team and other innovative, patient-focused models of care.

The AMA would also welcome inclusion in future consultations undertaken prior to the finalisation of the next community pharmacy agreement, as proposed in the Review interim report.

### **Pharmacy programs currently funded under the CPA (Chapter 8)**

The AMA recognises the valuable contribution pharmacists make in improving the quality use of medicines. Pharmacists working with doctors and patients can help ensure medication adherence, improve medication management, and provide education about medication safety.

The AMA fully supports ongoing and adequate funding of evidence-based pharmacist services such as home medicine reviews and the provision of dose administration aids.

As noted above, the AMA agrees it is important that government funded pharmacy programs are monitored and evaluated for effectiveness and cost effectiveness to ensure the expenditure provides tax payers with value for money. The findings from these evaluations will help improve and strengthen the programs.

The AMA considers that these programs should come under the same level of transparency and scrutiny as medical services do as a matter of course when they are examined through the Medical Services Advisory Committee process, and again now under the current MBS review.

### **Aboriginal and Torres Strait Islander people access (Chapter 9)**

The AMA fully supports the recommendations made to enhance access to medicines programs for Indigenous Australians and to support Aboriginal Health Service pharmacy ownership and operations.

**JULY 2017**

#### **Contact**

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